HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO 45 CFR 164.508

Name or specific identification of the person(s), or class of persons, authorized to make the requested disclosure:

Patient Name: Christopher Page, Jr. AKA:

Date of Birth: **Social Security Number:**

Address:

I authorize the disclosure of all protected medical information for the purpose of review and evaluation in connection with a legal claim. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information spanning the time period of first treatment to present including the following:

- All medical records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians.
- All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.
- All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/ cytology/ histology/ autopsy/ immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- All billing records including all statements, itemized bills, and insurance records.

Information about alcohol/substance abuse and HIV/AIDS may be disclosed as follows: (check all that apply)

____Yes, disclose HIV/AIDS information. OR __X__ No, do NOT disclose HIV/AIDS information.

__X__ Yes, disclose alcohol/substance abuse information OR ____ No, do NOT disclose alcohol/substance abuse information.

I authorize you to release the protected health information to: **Roger D. Landon, Murphy Spadaro & Landon, 1011 Centre Road, Suite 210, Wilmington, DE 19805, Tel: 302-472-8112, Fax: 302-225-3673.**

This authorization does not apply to psychotherapy notes, psychiatric or psychological records.
I acknowledge the right to revoke this authorization by writing to Roger D. Landon at Murphy Spadaro & Landon at the above referenced address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
I acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected under 45 CFR 164.508.
I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization.
Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.
This authorization expires two years from the date below.

Signature: _____ Date: _____

Relationship to the person who is the subject of the records: Self: ___X___ Other: _____
Describe authority